Division of Health Care Facili STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 07/30/2014	
		TN7104	e. WING				
	ROVIDER OR SUPPLIER	. STREE	T ADDRESS, CITY, ST				
STANDIN	G STONE CARE AN	D REHAB MON	TEREY, TN 38574		PDECTION	0(6)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X6) COMPLET DATE		(X6) COMPLETÉ DATE	
N 000	Initial Comments		N 000				
	#24940 ware com	r and complaint investigation pleted on July 28 - 30, 2014	1,월(. 1	
	Ctding Stopo	are and Rehab. No deficier Chapter 1200-8-6, Standard	CI62-1				
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Division	of Health Care Facilities	ROVIDER/SUPPLIER REPRESENTAT	TIVES SIGNATURE	TIYLE	 	(XB) DATE	
District		· 	9600	658K11	If co	ntinuation sheet	

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